TASC

Technical Assistance and Services Center

Flex Program Hour Highlights

Date: March 8, 2000
Topic: Reimbursement Issues
Facilitator: Tony Wellever, Delta Rural Health
Technical Advisors: Karen Travers, Travers Associates
Bob Ellis, Travers Associates
Curt Mueller, Project Hope

Tony Wellever opened the meeting by summarizing current reimbursement issues facing Flex Programs in relation to the conversion of critical access hospitals (CAHs). The main issues are:

- The Balanced Budget Act of 1997 (BBA) specifies that both professional and facility costs are to be included in an "all-inclusive" rate which would have allowed CAHs to be reimbursed at cost for salaried physicians' services. However, the language in the Balanced Budget Refinement Act (BBRA) was apparently changed at the last minute and now indicates payment for MD services on site is limited to the Medicare physician fee schedule.

- Due to an error in the drafting of the BBRA, it appears CAHs must now bill for lab services on the laboratory fee schedule rather than on a cost basis.

Karen Travers and Bob Ellis of Travers Associates (207-622-9315 or ktravers@westportgroup.com, bellis@westportgroup.com) explained the background of the all-inclusive rate issue: Based on the RPCH model, CAHs were to intended to be allowed to bill for physician services and for the overhead costs associated with those services and have them paid on a cost basis rather than having the physician bill under regular Part B of Medicare and be paid under the physician fee schedule. In the final BBRA language, the Act made payment for these services limited to the Medicare physician fee schedule. Therefore, the BBRA produced no substantive changes on this issue from BBA 1997, except that the original two payments can now be made in one check.

This issue also undermines the networking incentive to CAHs for enhanced reimbursement. Physicians will have no financial incentive to associate with the CAH.

The identified options for a solution are:

- Prompting a letter of instruction from HCFA, which could fix the problem in less than a year. However, this is not seen as a viable option.
- Changing the legislation, which could take 12-18 months.

The question was raised as to what existing CAHs are currently being paid for physician-based services. Concern was also voiced as to whether the proposed amendment change would be retroactive. Apparently retroactivity has not been addressed. There is no lead organization pushing for a fix on this issue and no legislative champion.

Curt Mueller (301-656-7401 or cmueller@projhope.org) of Project Hope spoke next. He has been asked by the Office of Rural Health Policy to gather information about the impact of the lab reimbursement issue. Curt noted that this is a difficult issue to address because we don't know what the cost-based reimbursement would have been. Project Hope has obtained 1995 numbers from HCFA from which to estimate impact. The average CAH is estimated to generate 6% of its total revenue from outpatient lab revenue, greater than most urban hospitals. This estimate had a range from 1%-11%, and is based on a crude measurement off the size of the outpatient department.

Financial feasibility assessments done for hospitals that have already converted to CAH were based on cost-based reimbursement. First and second year performance will be impacted greatly due to this. Some states quickly pointed out that some hospitals in their states are now backing out of the CAH conversion due to the uncertainty on this issue. TASC will work to gather additional information from the states to determine the scope of the impact.

Participants noted that HCFA's concern about cost-reimbursement is that it's like writing a blank check for services. In order to control cost, they want to place some kind of cap on reimbursement. This means that instead of being reimbursed based on a fee schedule, hospitals can have costs reimbursed up to a specified amount. But because we don't have information on cost behavior of CAHs yet, we don't have a basis for "reasonable cost." Small hospitals and hospitals outside of the "lower 48" are in additional jeopardy because their costs are relatively higher.

Several conference call participants remarked that the CAH-related reimbursements are particularly troubling because staff lacks expertise in this area and hospitals are requesting financial information before converting. TASC is available to provide assistance with the more complex financial issues.